TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-16-0141-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 8/31/2015 our appeal was processed with a payment of $481.53 which is an underpayment in the amount of $115.06."

Amount in Dispute: $553.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The fee schedule/customary guidelines provide the payment amount is $481.53 which is what was paid. The remaining amount is not recoverable as it is an excess of the fee schedule."

Response Submitted by: Smith & Carr, P.C. 9235 Katy Freeway, Suite 200, Houston, Texas 77024

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2015	E0730 -RR, E0731 -NU	$553.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Rental reimbursements have not reached the threshold value or the rental payments have been reimbursed less than maximum number of occurrences
   - 2 – The amount paid reflects the usual and customary charge

- 5 – The charge for this procedure exceeds the customary charges by other providers for this service
- 4 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (b) requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;"

   The applicable Medicare payment policy is found at, www.cms.hhs.gov, Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13), "In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months."

   28 Texas Administrative Code 134.203(d) states,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
   > >
   > > (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS;

   The service in dispute will be calculated as follows:

   - DMEPOS fee schedule 2015, Texas, E0730 (397.07) ÷ 10 (see above referenced Medicare payment policy) = $39.70 x 125% = $49.64
   - DMEPOS fee schedule 2015, Texas, E0731, $336.52 x 125% = $420.65

2. The total allowable reimbursement for the services in dispute is $470.29. The carrier previously paid $481.53. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 12, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.